Health Care
Innovation Initiative

Patient Centered Medical Homes (PCMH)
Technical Advisory Group (TAG) Recommendations and Program Information

PCMH program information

- A Sources of value
- B Care delivery model
- C Patient engagement
- D Eligibility requirements
- E Activities
- F Training and supports
- G Provider report design
- H Quality metrics

A PCMH sources of value

Sources of value

- **Appropriateness of care setting and forms of delivery** (e.g., increase in PCP visit to reduce ED utilization for medical conditions)
- **Increased access to care** (e.g., open office hours, open scheduling for walk-in appointments, and after-hours availability)
- **Improved treatment adherence** (e.g., adherence to mood stabilizer regimen, adherence to scheduled PCP visits)
- **Medication reconciliation**
- **Appropriateness of treatment**
- **Enhanced chronic condition management** (e.g., more frequent monitoring of A1c for diabetics)
- **Referrals to high-value medical and behavioral health care providers**
- **Reduced readmissions** through effective follow-up and transition management

B PCMH care delivery improvement model

	Stage 1: Providers in transition	Stage 2: Emerging model	Stage 3: Steady-state transformation

Primary patient prioritization	• All patients in PCMH
	• Primary PCMH prioritization and focus on patients with **chronic conditions and existing PCP contact** due to near-term value capture
		• Additional prioritization and focus on patient groups including:
		  ▫ **Chronic conditions but no PCP contact**
		  ▫ **Patients at risk** of developing chronic condition
			• **Broader focus on all patients** including healthy individuals

Focus for care delivery improvements	• Changes in **direct control of PCP** including
	  ▫ Enhance access and continuity (e.g., office-hours, after-hours access)
	  ▫ Provide self-care support and community resources including wraparound support
	  ▫ Plan and manage care by developing evidence-based care plan with input from patient and their family
	  ▫ Refer to high-value providers
	• Greater emphasis on **diagnosis and treatment of low-acuity behavioral health needs**
	• **Measure and improve performance**
		Additional priorities to include:
		• Practice at **top of license** including use of extenders
		• **Joint decision-making with behavioral health providers** and other specialists
		• Improve integrity of **care transitions**
		• Address **social determinants of health**
			Additional priorities to include:
			• **Multi-disciplinary team-based care** including regular interactions in-person
			• **Full IT connectivity across providers**
			• **Co-location of behavioral and physical healthcare** where feasible
			• **Health and wellness screenings, outreach, and engagement**

C Patient engagement

	Recommendation	Examples
Educate patients	• Orient patients on PCMH program • Teach patients how to stay engaged in one's own health • Educate patients on options in their own care to increase patient autonomy • Create expectation for patients that their first visit is about getting to know PCP	• Play "Welcome to Medicaid" videos and other interactive modules in clinic lobby, similar to Medicare introductory materials • Provide patients with toolkit covering key topics associated with one's own care, e.g.: "How to keep track of your medicine" • Give patients plastic cards that say, "Stop! Before you go to the ER call this number", which leads to a staff nurse line • Provide patients with an actionable menu of options in care planning • Build in more time during initial patient visit to 'get to know' patient
Eliminate barriers to care	• Actively address social determinants of health (e.g., food, employment, transportation, family) • Utilize existing tools to screen for social determinants of health in pediatrics • Engage/connect with high needs behavioral health members in Health Homes	• Build formal relationships with local social service agencies (e.g., through care coordinators) • Transportation carriers in Memphis already offer reimbursement to those in need • Establish partnerships with legal entities to provide legal aid
Incentivize patients to engage	• Allow formal incentives for patients to engage in their own care (if feasible)	• Offer a gift card for each appointment attended on schedule and on time

PCMH provider requirements

Commitment	• Stated commitment to the goals of value-based payment including, but not limited to: increased care coordination, proactive management of the patient panel, a focus on quality and outcomes, and integrated care across multidisciplinary provider teams
Minimum panel size	• Requirement of 500 patients with a single MCO to enter program
Practice type	• Eligible primary care TennCare practice type (i.e., family practice, general practice, pediatrics, internal medicine, FQHC, local health department) with one or more PCPs (including nurse practitioners)
Personnel	• Designation of PCMH Director who will have an ongoing physical presence in your organization

PCMH provider requirements

Training and Collaboration	• All organizations will have access to 2 years of practice transformation training and support • Share best practices with other participating PCMH organizations and support other organizations in their transformation by participating in learning collaboratives on an ongoing basis • Support future waves of PCMH participants in practice transformation
NCQA Accreditation	• Maintain Level 2 or 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) ***OR*** • Achieve NCQA's 2017[1] PCMH recognition
Tools	• Maintain an updated list of providers associated with your organization in the Provider Data Management System (PDMS) • Sign up and use the Care Coordination Tool in each PCMH site

[1]Information about NCQA's PCMH recognition program can be found here: http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

F Training and practice transformation services

Initial assessment	• An initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation • Focus of assessment to be strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement
Practice transformation support curriculum	• Develop and execute a standard curriculum that can be tailored for each primary care practice site based on the needs identified in the pre-transformation assessment • Should cover 1st and 2nd years of transformation including frequency and structure of learning activities • Curriculum may include content structured through the following: – Learning collaboratives – Large format in-person trainings – Live webinars – Recorded trainings – On-site coaching
Semi-annual assessment	• Conduct assessments of progress toward each practice transformation milestone every 6 months; document progress

Important to account for differing needs across practice profiles (e.g., size, urban / rural)

F Training and practice transformation services

Practice transformation support curriculum

The PCMH curriculum will focus on building health care provider capabilities for effective patient population health management to **reduce the rate of growth** in total cost of care while **improving health, quality of care, and patient experience**.

This curriculum will include, but is not limited to, content in the following areas:

- Delivering integrated physical and behavioral health services;
- Team-based care and care coordination;
- Practice workflow redesign and management;
- Risk stratified and tailored care delivery;
- Enhanced patient access (e.g., flexible scheduling, expanded hours);
- Evidence-informed and shared decision making;
- Developing an integrated care plan;
- Patient and family engagement (e.g., motivational interviewing);
- Making meaningful use of Health Information Technology (HIT)/ Health Information Exchange (HIE);
- Making meaningful use of the care coordination tool (e.g., ADT feeds);
- Making meaningful use of provider reports;
- Business support; and
- Clinical workflow management

G Provider Reports

- **Practice Overview**
  - Basic information (e.g., attributed beneficiaries)
  - Practice support payments received to date
- **Quality performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
- **Total cost of care**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks
  - For large practices only: Shared savings earned
- **Efficiency performance report**
  - Progress against previous performance
  - Comparisons to peer organizations and national benchmarks

- Align reporting (e.g., format, style) as much as possible across MCOs
- Be transparent in the event of reporting errors

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Quality Metrics for Pediatric Only and Adult Only PCMHs

Pediatric Practice Quality Metrics

1. **EPSDT screening rate (composite for older kids)**
   - Well-child visits ages 7-11 years
   - Adolescent well-care visits age 12-21
2. **Asthma medication management**
3. **Immunization composite metric**
   - Childhood immunizations
   - Immunizations for adolescents
4. **EPSDT screening rate (composite for younger kids)**
   - Well-child visits first 15 months
   - Well-child visits at 18, 24, & 30 months
   - Well-child visits ages 3-6 years
5. **Weight assessment and nutritional counseling**
   - BMI percentile
   - Counseling for nutrition

Adult Practice Quality Metrics

1. **Adult BMI screening**
2. **Antidepressant medication management**
3. **EPSDT: Adolescent well-care visits age 12-21**
4. **Comprehensive diabetes care (composite 1)**
   - Diabetes care: eye exam
   - Diabetes care: BP < 140/90
   - Diabetes care: nephropathy
5. **Comprehensive diabetes care (composite 2)**
   - Diabetes HbA1c testing
   - Diabetes HbA1c poor control (>9%)

Quality Metrics for Family Practices

Family Practice Quality Metrics

1	**Adult BMI screening**
2	**Antidepressant medication management**
3	**Comprehensive diabetes care (composite 1)**
	Diabetes eye exam
	Diabetes BP < 140/90
	Diabetes nephropathy
4	**Comprehensive diabetes care (composite 2)**
	Diabetes HbA1c testing
	Diabetes HbA1c poor control (> 9%)
5	**Asthma medication management**
6	**Immunization composite metric**
	Childhood immunizations
	Immunizations for adolescents
7	**EPSDT screening rate (Composite for youngest kids)**
	Well-child visits first 15 months
	Well-child visits at 18, 24, & 30 months
8	**EPSDT: Well-child visits ages 3-6 years**
9	**EPSDT Screening (Composite for older kids)** Well-child visits ages 7-11 years Adolescent well-care visits age 12-21
10	**Weight assessment and nutritional counseling** BMI percentile Counseling for nutrition